For Internal Use Only
PA#:
Date Entered:

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

SYNAGIS Referral Form

FAX Completed Form & Prescription to: (410) 424-4607

For Questions: Contact the Pharmacy Dept at: 410-424-4490, option 4 or 1-888-819-1043, option 4

Patient Information		**Physician Information**	
Member Name:		Physician Name :	
Member ID:		Office Contact:	
Date of Birth:		Office Phone:	
Gender:	☐ Male ☐Female	Office Fax:	
Parent/Guardian:		DEA #	

Prescription Information *(Prescription for Synagis MUST be attached)*

Synagis Vial Quantity: 100mg: _____ 50 mg: _____
SIG: Inject 15mg/kg IM one time per month
Desired Start Date: _____ Refill: _____ months

Birth Weight: _____ lbs or kg (circle one)
Current Weight: _____ lbs or kg (Required)
Actual Gestational Age: _____weeks (Required)

Approval Criteria *(If applicable, attach NICU discharge summary and/or supporting progress notes)*

☐ Age of 12 months or less & born at 29 wks or less gestation at beginning of RSV season

☐ Age of 12 months or less with Chronic Lung Disease (CLD/bronchopulmonary dysplasia) plus the following:
- ☐ born at less than 32 weeks gestation AND requires >21% oxygen for at least 28 days after birth

☐ Age of 12 months or less with hemodynamically significant Congenital Heart Disease plus one of the following:
- ☐acyanotic heart disease & receiving medication to control congestive heart failure & requires heart surgery OR
- ☐moderate to severe pulmonary hypertension

☐ Age of 12 months or less plus one of the following that compromises clearing secretions from upper airway:
- ☐ anatomic pulmonary abnormalities OR ☐neuromuscular disorder

☐ Age of 23 months or less with severe immunodeficiency

☐ Age of 23 months or less with CLD/bronchopulmonary dysplasia requiring treatment within 6 months prior to RSV season (born at less than 32 weeks gestation AND required >21% oxygen for at least 28 days after birth) and requires one of the following medical support: ☐oxygen ☐diuretics ☐corticosteroid

☐ Age of 23 months or less at the start of RSV season plus one of the following:
- ☐undergoing heart transplant OR ☐ Receiving prophylaxis & requires one additional post-operative dose

☐ Age of 23 months or less with Cystic Fibrosis and meets one of the following:
- ☐CLD and/or nutritional compromise at the age of 12 months or less OR
- ☐manifestations of severe lung disease during second year of life

☐ Office Reimbursement Requested. Provider will administer Synagis from office inventory and bill JHHC for reimbursement

☐ Arrange Specialty Pharmacy Delivery. JHHC will arrange office delivery from specialty pharmacy. The specialty pharmacy will contact provider office for confirmation prior to shipment.

I certify that the clinical information provided on this form is complete and accurate.

Provider Signature: _____ Today's Date: _____

For Internal Use only	Per CDC, Synagis season in the state of MD is from Nov- March
☐ Approved Number of doses_____	Duration of Approval:
☐ Denied	Reviewer:
Need more information:	Date: